



IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH - Governor
RICHARD M. ARMSTRONG - Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

December 11, 2006

FILE COPY

Lori Maupin
Idaho Kidney Center - Blackfoot LLC
98 Poplar Street
Blackfoot, ID 83221

Dear Ms. Maupin:

This is to advise you of the findings of the Medicare survey, which was concluded at your facility, Idaho Kidney Center - Blackfoot LLC, on November 20, 2006.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please call our office at (208)334-6626.

Sincerely,

GARY GUILLES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

GG/mlw

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/08/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13T019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2006
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IDAHO KIDNEY CENTER-BLACKFOOT, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR BLACKFOOT, ID 83221
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
V 000	<p>INITIAL COMMENTS</p> <p>No deficiencies were cited during the initial Medicare certification survey of your dialysis facility. Idaho Kidney Center-Blackfoot is in compliance with the requirements of 42 CFR Part 405, Conditions of Coverage for End-Stage Renal Disease Facilities. The surveyor conducting the initial Medicare certification survey was Gary Guiles, RN, HFS.</p>	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.